Claims Clues

A Publication of the AHCCCS Claims Department September, 1999

AHCCCS to Process QMB Only Claims

Effective with claims submitted on and after October 1, 1999, AHCCCS will begin processing claims for fee-for-service QMB Only recipients.

These recipients are not eligible for AHCCCS but are eligible for reimbursement of coinsurance and deductible of Medicare-covered services.

Providers must bill Medicare first. Claims from providers whose Medicare carrier is Blue Cross/Blue Shield of North Dakota, Blue Cross/Blue Shield of Arizona, or Blue Cross/Blue Shield of Texas will be automatically crossed over to AHCCCS.

Providers with Medicare carriers other than these must bill Medicare first, then submit a paper claim and the Medicare EOMB to AHCCCS. Also, providers who need to adjust a paid claim for a QMB Only recipient must bill Medicare first, then submit a paper claim and the EOMB to AHCCCS.

Paper claims should be mailed to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

Providers who have questions about claims for QMB Only recipients should contact the Claims Customer Service Unit at (602) 417-7670 (Option 4). ❒

Email Address Needed for Electronic Remittance

A provider must have an Internet email address in order to receive the AHCCCS Fee-for-Service Remittance Advice in an electronic format.

The Remittance Advice will be transmitted to providers via the Internet to the provider's email address. The Remittance Advice will be a file attachment to an email, and it will retain its current content.

Providers who select the electronic Remittance Advice will no longer receive a paper copy of the document.

Electronic transmission of the Remittance Advice does **not** include electronic deposit of reimbursement checks. Reimbursement checks will continue to be mailed to the provider's pay-to address.

A provider must complete an authorization form in order to receive the electronic Remittance Advice. The authorization form must be signed by the provider or the provider's designated agent.

The authorization form was attached to the July and August issues of *Claims Clues*, which are available on the AHCCCS Web Site at www.ahcccs.state.az.us. The form also is available by contacting the AHCCCS Provider Registration Unit at (602) 417-7670 (Option 5).

AHCCCS expects to make the electronic Remittance Advice available by October 1. ❒

Initial Claim To Be Due 6 Months from DOS

Effective with claims with an ending date of service on or after October 1, 1999, fee-for-service claims must be initially received by AHCCCS not later than 6 months from the ending date of service unless the claim is a retro-eligibility claim. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

Claims with dates of service prior to October 1 remain subject to the 9-month deadline.

Regardless of dates of service, claims must attain clean claim status no later than 12 months from the date of service, unless the claim is a retro-eligibility claim.

A retro-eligibility claim for a categorically eligible recipient with an ending date of service on or after October 1 must be initially received by AHCCCS no later than 6 months from the date of eligibility posting. For dates of service prior to October 1, the deadline remains at 9 months from the eligibility posting date.

All retro-eligibility claims must attain clean claim status no later than 12 months from the date of eligibility posting. ❒

Guidelines Offered for Submitting Documentation

The AHCCCS Claims Medical Review Unit is offering guidelines to providers for submitting documentation with fee-for-service claims.

While it is impossible to offer specific guidelines for each situation, the tables below are designed to give providers some general guidance regarding submission of documentation. Also, not all fee-for-service claims submitted to AHCCCS are subject to Medical Review. ❒

	HCFA 1500 Claims	
Billing For	Documents Required	Comments
Surgical procedures	H&P and operative report	
Missed AB/Incomplete AB Procedures (all CPT codes)	H&P, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Emergency room visits	Emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes/H&P/office records/ D/C summary/consults	Documentation should be specific to code billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report and H&P	Examples: Cardiac caths, Doppler studies etc.

	UB-92 Claims	
Billing for	Documents Required	Comments
Observation	All statutory required documents & observation records	If L&D, send labor and delivery records
Missed AB/Incomplete AB	All statutory required documents, ultrasound report , operative reports, pathology report	Information must substantiate fetal demise
NICU/ICU tier claims	All statutory required documents	MD orders and MD progress notes to substantiate level of care billed
Outlier	All statutory required documents	

Providers should *not* submit the following unless specifically requested to do so:

- Emergency admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (exception: BTL & hysterectomy)
- Ultrasound/X-ray *films*
- Medifax information
- Nursing care plans
- Medication administration records (MAR)
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays
- Entire medical records ❒

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

The following codes have been end-dated effective September 30, 1999 for provider type 79 (Vision center): 92002, 92012, 92060, 92065, 92081, 92082, 92083, 92393, and 92499.

Effective October 1, 1999, this provider type may bill the following codes: 92340-92392, 92395, and 92396 ❒

KidsCare Income Ceiling Raised to 200% FPL

The income ceiling for KidsCare recipients will rise to 200 per cent of the federal poverty level (FPL) beginning October 1, 1999.

Currently the ceiling is at 150 per cent of FPL, meaning that a family of four earning about $2,088 per month would qualify. On October 1, the income limit will rise to about $2,784 a month for a family of four.

Other eligibility criteria are: U.S. citizen or qualified alien, Arizona resident, not eligible for Medicaid or Medicare, and not covered under an employer's insurance in the last six months.

KidsCare is a free or low-cost children's health insurance program administered by AHCCCS for children under the age of 19 whose families do not have health insurance because their employer does not offer it, they can't afford family coverage, or they earn too much to qualify for AHCCCS (Medicaid).

Families with incomes between 150 and 200 per cent of FPL are required to pay a small monthly premium to AHCCCS. The KidsCare approval letter advises families of the premium amount and due date.

Most health services covered under AHCCCS are covered under KidsCare, with the exception of non-emergency transportation. There also are limitations on behavioral health and vision benefits.

Health care is provided through the AHCCCS health plans, Indian Health Service and 638 tribal facilities, and Arizona Department of Health Services Direct Services providers.

Providers who want to learn more about the program, order applications and materials for their office, or refer someone who may be eligible for KidsCare should call the KidsCare Hotline at 1-877-764-KIDS (5437) or (602) 417-5437. ❒

Programs Help Individuals Pay for Coverage

In addition to serving as the State of Arizona's Medicaid agency, AHCCCS also administers the Premium Sharing Program and four Medicare Cost Sharing Programs that help individuals pay for health care coverage.

The ***Premium Sharing Program*** is a pilot program available in Cochise, Maricopa, Pima and Pinal counties. The program provides health care benefits to uninsured people who earn too much to be eligible for Medicaid (about $2,784 per month for a family of four.)

Because the program is a pilot, the number of participants is limited. If no spaces are available, eligible persons will be placed on a waiting list. The number of people with chronic illnesses who may participate in the program is limited to 200.

A monthly premium is charged, based on the family's gross monthly income and the size of the family. Two months' premiums must be paid at the beginning of coverage, and premiums must be paid in full every month for coverage to continue. In addition, co-payments are charged at the time the person receives services.

Covered services are very similar to AHCCCS-covered services, with the exception of non-emergency transportation. There are limitations on behavioral health services, and transplants are not covered unless an individual is chronically ill.

Services are provided through three AHCCCS-contracted health plans: Arizona Physicians, Mercy Care and University Physicians.

Providers who want to learn more about the program, order applications or materials, or refer someone to the program should call 1-888-308-6516 or (602) 417-6700.

AHCCCS also administers four ***Medicare Cost Sharing Programs*** that may pay for some or all of the Medicare premiums, co-pays or deductibles for an eligible person.

These four programs and their income requirements are:

Qualified Medicare Beneficiary (QMB)

$0 - $687/mo (single)
$0 - $922/mo (couple)

- Pays Medicare Part A and B premiums, co-pays, and deductibles

Specified Low Income Medicare Beneficiary (SLMB)

$687.01 - $824/mo (single)
$922.01 - $1,106/mo (couple)

- Pays Part B premium

(Continued on Page 4)

Programs Help Individuals Pay for Coverage

(Continued from Page 3)

Qualified Individual 1
$824.01 - $927/mo (single)
$1,106.01 - $1,245/m (couple)
- Pays Part B premium

Qualified Individual 2
$927.01 - $1,202/mo (single)
$1,245.01 - $1,613/mo (couple)
- Partial reimbursement toward Part B premium

Other eligibility criteria include: U.S. citizen or qualified alien, Arizona resident, and total countable resources (cash, bank accounts, etc.) of not more than $4,000 for a single person or $6,000 for a couple. The value of an applicant's residence is not counted, and some or all of the value of an applicant's vehicle may not be counted.

Applicants can visit or call one of the AHCCCS field offices for an application. No face to face interview is required, and they can mail in the completed application.

Call 1-800-528-0142 for the location of the nearest AHCCCS field office.

Providers who would like to order posters, brochures, and applications for their office should call 1-800-654-8713, Ext. 4065 or (602) 417-4065 and ask for Jay. ❐

ESRD Facility Claims Face Prepayment Review

AHCCCS is conducting a prepayment review of all fee-for-service claims from free-standing dialysis facilities (provider type 41).

Documentation justifying medical necessity will be required for medical review of claims for the following services:

- EPO greater than 10,000 units/ administration
- EPO greater than 100,000 total units
- Hematocrit rolling average (HRA) > 36.0
- Blood or laboratory tests on blood (revenue code 390)
- All drugs except Calcijex and Infed
- All vaccines except influenza and pneumonia
- Bone density tests, EKG, and nerve conduction tests
- Hemodialysis treatments exceeding 14 units in one month

Services for which medical documentation is not provided will be denied.

Providers who need to submit documentation after the claim has been submitted to AHCCCS must write the AHCCCS Claim Reference Number (CRN) on the documentation. The documentation will be imaged and linked to the claim image.

Dialysis facilities are reimbursed a composite rate. Services included in the composite rate may not be billed separately unless the services are provided more frequently than specified by policy. AHCCCS follows Medicare policy for billing and reimbursement of dialysis services. ❐

Providers Must Be Present at AHCCCS Hearings

Billing services and similar entities may not represent providers at AHCCCS hearings conducted by the Arizona Office of Administrative Hearings.

A provider will be considered to have defaulted if an employee of the provider is not present at these hearings. A billing service representative may attend the hearings and advise the provider.

Providers who wish to cross-examine witnesses and make opening and closing statements at AHCCCS hearings do not need legal representation, according to the Arizona Supreme Court.

The Supreme Court said earlier that opening and closing statements and cross-examination of witnesses could only be done when there is legal representation.

The AHCCCS Administration sought and was granted an exception for AHCCCS contractors and providers.

Effective July 1, all AHCCCS hearings are conducted by the Office of Administrative Hearings, an independent state agency.

An administrative law judge will conduct the hearing and make a recommendation to the AHCCCS director, who will issue the director's decision.

A petition for a re-hearing must be submitted within 30 days of the director's decision. The director will determine whether to amend the decision or order a re-hearing.

The AHCCCS Office of Legal Assistance (OLA) no longer conducts hearings. However, providers must still file grievances and appeals with OLA. The OLA Informal Resolution Unit will continue to render written grievance decisions. ❐